

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043065

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 186 Primary Registration District No. 3026 Registrar's No. 562

FILED NOV 20 1962

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u>		Length of stay in 1b <u>15 Yr.s</u>	c. CITY OR TOWN <u>Independence</u> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Independence Sanitarium</u>		d. STREET ADDRESS (If outside, give location) <u>580 S Glenwood</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Wallace Johnson</u>		4. DATE OF DEATH Month Day Year <u>Nov 4 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-9-1893</u>
9. AGE (last birthday) <u>69</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <u>Calhoun Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>William L Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Minerva J Hudson</u>	
14. NAME OF HUSBAND OR WIFE <u>Alec Johnson</u>		Address <u>Independence Mo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>[Redacted]</u>	
17. INFORMANT <u>Alec Johnson</u>		Address <u>Independence Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Abdominal Aneurysm</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-sclerosis-generalized</u> DUE TO (c) <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture of hip & Duodenal Stricture</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour s.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>10/18/62</u> to <u>11/4/62</u> and last saw him alive on <u>11/4/62</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>Fred W. Smith M.D.</u> (Degree or title)	
22b. ADDRESS <u>10229 Independence Independence Mo</u>		22c. DATE SIGNED <u>11/5/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>11-5-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calhoun Cem</u>		23d. LOCATION (City, town, or county) <u>Calhoun Missouri</u>	
24. FUNERAL DIRECTOR <u>Sickman & Dunning Clinton Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-5-62</u>	
26. REGISTRAR'S SIGNATURE <u>Alba L. Craig</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

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Rev. 4/59

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NOV 21 1962

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. L. Running

Licensed Embalmer No. 4910

P. O. Address Clinton mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.